No. 15-274

IN THE

Supreme Court of the United States

WHOLE WOMAN'S HEALTH, *et al.*,
Petitioners,

v.

KIRK COLE, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES, *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF FOR AMICI CURIAE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN OSTEOPATHIC ASSOCIATION, AND AMERICAN ACADEMY OF PEDIATRICS IN SUPPORT OF PETITIONERS

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CASES

Page(s)

Planned Parenthood Southeast, Inc. v. *Strange*, 33 F. Supp. 3d 1330 (M.D. Ala.), *supplemented by* 33 F. Supp. 3d 1381 (M.D. Ala.), *and amended by* 2014 WL 5426891 (M.D. Ala. Oct. 24, 2014) 22

Planned Parenthood of Wisconsin, Inc. v. *Schimel*, 806 F.3d 908 (7th Cir. 2015) 20, 21

STATUTES, RULES, AND REGULATIONS

22 Tex. Admin. Code §§ 192.1-192.6 15

25 Tex. Admin. Code § 135.52(f)(5)(C) 12

Tex. Health & Safety Code Ann.
§ 171.004 6
§ 171.0031(a)(2)(B) 20
§ 245.004 6

38 Tex. Reg. 6536 (Sept. 27, 2013) 19

OTHER AUTHORITIES

ACOG, *College Statement of Policy, Abortion Policy* (2014), *available at* https://www.acog.org/-/media/Statements-of-Policy/Public/sop069.pdf?dmc=1&ts=20151230T1602484161 ..... 5, 22, 26

ACOG, Committee on Health Care for Underserved Women, *Committee Opinion Number 613, Increasing Access to Abortion*, 124 Obstetrics & Gynecology 1060 (2014) 5, 24

TABLE OF AUTHORITIES—Continued

Page(s)

ACOG, Committee on Patient Safety & Quality Improvement, *Committee Opinion Number 459, The Obstetric-Gynecologic Hospitalist*, 116 Obstetrics & Gynecology 237 (2010) 19

ACOG, *Frequently Asked Questions, Induced Abortion* (2015), *available at* http://www.acog.org/~/media/For%20Patients/faq043.pdf 10

ACOG, *Guidelines for Women's Health Care: A Resource Manual* (4th ed. 2014) 18

ACOG, *Patient Education Pamphlets: Colposcopy* (2013) 13

ACOG, *Patient Education Pamphlets: Endometrial Hyperplasia* (2012) 13

ACOG, *Patient Education Pamphlets: Hysteroscopy* (2011) 13

ACOG, *Patient Education Pamphlets: Loop Electrosurgical Excision Procedure* (2013) 13

ACOG, *Practice Bulletin Number 143, Medical Management of First-Trimester Abortion*, 123 Obstetrics & Gynecology 676 (2014) 11

ACOG, *Report of the Presidential Task Force on Patient Safety in the Office Setting* (2010), *available at* http://www.scopeforwomenshealth.org/ckfinder/userfiles/files/Task%20Force%20Report%20(final).pdf 21

TABLE OF AUTHORITIES—Continued

Page(s)

ACOG, *Statement of Policy, Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (2013), *available at* https://www.acog.org/-/media/Statements-of-Policy/Public/2013LegislativeInterference.pdf?dmc=1&ts=20151230T1634176854 5

Allen, Rebecca H., et al., *Pain Relief for Obstetric and Gynecologic Ambulatory Procedures*, 40 Obstetrics & Gynecology Clinics N. Am. 625 (2013) 13, 14

American College of Surgeons, *Statement on Patient Safety Principles for Office-Based Surgery Utilizing Moderate Sedation/Analgesia, Deep Sedation/Analgesia, or General Anesthesia*, 89 Bull. Am. Coll. Surgeons 32 (2004), *available at* https://www.facs.org/about-acs/statements/46-office-based-surgery 21

American Society for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745 (2011) 15

Bartlett, Linda A., et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729 (2004) 23

TABLE OF AUTHORITIES—Continued

Page(s)

Dennis, Amanda, et al., *Barriers to and Facilitators of Moving Miscarriage Management Out of the Operating Room*, 47 Persp. on Sexual & Reprod. Health 141 (2015) 14

Godfrey, Emily M., et al., *Early Pregnancy Loss Needn't Require a Trip to the Hospital*, 58 J. Fam. Prac. 585 (2009) 14

Grazer, Frederick M. & Rudolph H. de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436 (2000) 15

Grimes, David A., et al., *Abortion Facilities and the Risk of Death*, 13 Fam. Plan. Persp. 30 (1981) 9

Grimes, David A., et al., *Comparative Risk of Death from Legally Induced Abortion in Hospitals and Nonhospital Facilities*, 51 Obstetrics & Gynecology 323 (1978) 9

Grossman, Daniel, et al., *Change in Abortion Services After Implementation of a Restrictive Law in Texas*, 90 Contraception 496 (2014) 23, 24

Grossman, Daniel, et al., *Complications After Second Trimester Surgical and Medical Abortion*, 16 Reprod. Health Matters 173 (2008) 23

TABLE OF AUTHORITIES—Continued

Page(s)

Grossman, Daniel, et al., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas*, Texas Policy Evaluation Project Research Brief (2015) 25

Grossman, Daniel, et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 Contraception 73 (2014) 17, 24, 25

Hellerstein, Erica, *The Rise of the DIY Abortion in Texas*, The Atlantic, June 27, 2014, http://www.theatlantic.com/health/archive/2014/06/theriseofthediyabortionintexas/373240/ 25

Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001) 18, 19

Joyce, Theodore, *The Supply-Side Economics of Abortion*, 365 New Eng. J. Med. 1466 (2011) 10

Lohr, Patricia A. & Richard Lyus, *Dilatation and Evacuation*, in *Abortion Care* 88 (Sam Rowlands ed., 2014) 12

National Abortion Federation, *2015 Clinical Policy Guidelines* (2015) 18

Nichols, Mark, et al., *A Comparative Study of Hysteroscopic Sterilization Performed In-Office Versus a Hospital Operating Room*, 13 J. Minimally Invasive Gynecology 447 (2006) 13

TABLE OF AUTHORITIES—Continued

Page(s)

Paul, Maureen, *Office Management of Early Induced Abortion*, 42 Clinical Obstetrics & Gynecology 290 (1999) 9, 12

Pazol, Karen, et al., *Abortion Surveillance—United States, 2012*, 64 Morbidity & Mortality Wkly. Rep. 1 (2015) 6, 7, 11, 23

Peacock, Lisa M., et al., *Transition to Office-Based Obstetric and Gynecologic Procedures: Safety, Technical, and Financial Considerations*, 58 Clinical Obstetrics & Gynecology 418 (2015) 9, 10, 14

Raymond, Elizabeth G. & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215 (2012) 7

Rock, John A. & Howard W. Jones III, *TE Linde's Operative Gynecology* (10th ed. 2011) 10, 12

Senate Committee on Health & Human Services, Bill Analysis, Tex. H.B. 2, 83d Leg., 2d C.S. 1 (2013) 16

Shah, Iqbal H., et al., *Access to Safe Abortion: Progress and Challenges Since the 1994 International Conference on Population and Development (ICPD)*, 90 Contraception S39 (2014) 25

TABLE OF AUTHORITIES—Continued

Page(s)

Soffen, Kim, *How Texas Could Set National Template for Limiting Abortion Access*, N.Y. Times, Aug. 19, 2015, http://nyti.ms/1E36Zjc 20, 22

Texas Department of State Health Services, *2014 Healthy Texas Babies: Data Book* (2014), *available at* http://www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=85899933342 7

Texas Department of State Health Services, *Vital Statistics Annual Reports*, http://www.dshs.state.tx.us/chs/vstat/annrpts.shtm (last updated Oct. 15, 2015) 7, 8, 9, 14

Upadhyay, Ushma D., et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175 (2015) 8, 19

Urman, Richard D., et al., *Safety Considerations for Office-Based Obstetric and Gynecologic Procedures*, 6 Revs. Obstetrics & Gynecology e8 (2013) 14

Weitz, Tracy A., et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Pub. Health 454 (2013) 8

TABLE OF AUTHORITIES—Continued

Page(s)

Whether Abortion Facilities that are Exempt from Licensing Under Section 245.004 of the Health and Safety Code are Subject to Regulation by the Texas Department of Health Under Chapter 245, Op. No. GA-0212 (Tex. Att'y Gen. July 7, 2004) 6

White, Kari, et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 C ntraception 422 (2015) 8, 9, 16, 18

STATEMENT OF INTEREST OF AMICI CURIAE

The American College of Obstetricians and Gynecologists (the "College" or "ACOG"), the American Medical Association ("AMA"), the American Academy of Family Physicians ("AAFP"), the American Osteopathic Association ("AOA"), and the American Academy of Pediatrics ("AAP") submit this amici curiae brief in support of Petitioners.[1]

ACOG is a non-profit educational and professional organization founded in 1951. The College's objectives are to foster improvements in all aspects of the health care of women; to establish and maintain the highest possible standards for education; to publish evidence-based practice guidelines; to promote high ethical standards; and to encourage contributions to medical and scientific literature. The College's companion organization, the American Congress of Obstetricians and Gynecologists (the "Congress"), is a professional organization dedicated to the advancement of women's health and the professional interests of its members. Sharing more than 57,000 members, including 2,549 obstetrician-gynecologists in Texas, the College and the Congress are the leading professional associations of physicians who specialize in the health care of women.

The College and the Congress recognize that abortion is an essential health care service and oppose laws

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[1] Pursuant to Rule 37.3(a), letters of consent to the filing of this brief are on file with the Clerk of the Court. No counsel for a party authored this brief in whole or in part and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of the brief. No person or entity other than amici or their counsel made a monetary contribution to the preparation or submission of this brief.

regulating medical care that are unsupported by scientific evidence and that are not necessary to achieve an important public health objective.

The College has previously appeared as amicus curiae in various courts throughout the country, including this Court. In addition, the College's work has been cited by numerous courts seeking authoritative medical data regarding childbirth and abortion.

AMA is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in the AMA's House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policymaking process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in all fields of medical specialization and in every state, including Texas. This Court and the federal courts of appeal have cited the AMA's publications and amicus curiae briefs in cases implicating a variety of medical questions.

AAFP is headquartered in Leawood, Kansas, and is the national medical specialty society representing family physicians. Founded in 1947 as a not-for-profit corporation, its 120,900 members are physicians and medical students from all 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Uniformed Services of the United States. The AAFP seeks to improve the health of patients, families, and communities by advocating for the health of the public and serving the needs of members with professionalism and creativity.

AOA, established in 1897, is the national professional association for the more than 110,000 osteopathic physicians (Doctors of Osteopathic Medicine or DOs) and medical students enrolled in accredited colleges of osteopathic medicine in the United States. This includes more than 3,500 osteopathic physicians who practice in the specialty of obstetrics and gynecology. The AOA is recognized by the United States Department of Education as the accrediting agency for colleges of osteopathic medicine. Since 1943, the AOA's American Osteopathic Board of Obstetrics and Gynecology has offered a program of specialty and subspecialty board certification for osteopathic obstetricians and gynecologists. The AOA is dedicated to promoting public health, to encouraging scientific research, and to maintaining and improving high standards of osteopathic medical education.

AAP was founded in 1930 and is a national, not-for-profit organization dedicated to furthering the interests of child and adolescent health. Since AAP's inception, its membership has grown from 60 pediatricians to more than 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. Over the past 85 years, AAP has become a powerful voice for child and adolescent health through education, research, advocacy, and the provision of expert advice. AAP has worked with the federal and state governments, health care providers, and parents on behalf of America's families to ensure the availability of safe and effective reproductive health services.

INTRODUCTION AND SUMMARY OF ARGUMENT

Reproductive healthcare is essential to a woman's overall health, and access to abortion is an important component of reproductive healthcare. Amici curiae are leading medical societies, whose policies represent the considered judgments of the many physicians in this country. Amici's position is that laws that regulate abortion should be supported by a valid medical justification. Texas is one of a number of states that have enacted laws that lack such a justification and, if allowed to stand, would restrict access to otherwise safe and professional care.

Passed in 2013, Texas House Bill ("H.B.") 2 requires that abortion facilities—such as outpatient clinics where the majority of abortions in Texas are performed—conform to the standards of ambulatory surgical centers (the "ASC requirement"), notwithstanding that the legal abortions performed in Texas prior to the passage of H.B. 2 met or exceeded safety expectations for outpatient medical procedures. H.B. 2 also requires that abortion providers obtain admitting privileges at local hospitals (the "privileges requirement"), even though such privileges are unnecessary for safe patient care and can be difficult or impossible to obtain for reasons unrelated to a clinician's competence.

Neither requirement is supported by accepted medical practice or scientific evidence. There is no medically sound reason to assume that abortions performed in a hospital or ASC setting are safer than those performed in a clinic or office, and requiring abortion clinics to meet the standards for ASCs has no medical purpose given the nature and simplicity of abortion procedures. The admitting privileges requirement likewise does nothing to improve the health and safety

of women. In fact, it is inconsistent with prevailing medical practice, which provides for continuity of care regardless of whether the clinician has local admitting privileges. Moreover, there is incontrovertible evidence that imposing these unjustified burdens on abortion providers is impeding women's access to quality, evidence-based medicine: H.B. 2 has delayed, and in some cases blocked, women's access to legal abortion. Both outcomes jeopardize women's health.

Patient safety is of paramount concern to amici, and amici support laws that are necessary to protect patient safety. Laws that regulate abortion should be evidence-based and designed to improve women's health.[2] The challenged provisions of H.B. 2 are neither.

ARGUMENT

I. H.B. 2's ASC Requirement Imposes Medically Unnecessary Demands On Abortion Facilities And Serves No Medical Purpose

Contrary to Texas's assertion that abortion procedures would be safer if performed in ASCs,[3] H.B. 2's

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[2] *See, e.g.*, ACOG, Comm. on Health Care for Underserved Women, *Committee Opinion Number 613, Increasing Access to Abortion*, 124 Obstetrics & Gynecology 1060, 1062 (2014) (explaining that the College opposes medically unnecessary physical plant and admitting privileges requirements); ACOG, *College Statement of Policy, Abortion Policy* 2 (2014) (opposing "unnecessary regulations that limit or delay access to care"); *see also* ACOG, *Statement of Policy, Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (2013).

[3] Pet. App. 25a ("The Texas Legislature's stated purpose for enacting these provisions was to raise the standard and quality of care for women seeking abortions and to protect the health and welfare of women seeking abortions."); Opp. 3, 24; Resp. C.A. Br. 13, 35-36.

requirement that abortion facilities[4] meet the standards for ASCs lacks any evidence-based medical or scientific justification.[5]

A. Abortion Is An Extremely Safe Medical Procedure And No Medical Evidence Suggests That Abortion Would Be Safer If Performed In An ASC Setting

Abortion is one of the safest medical procedures performed in the United States. The risk of death resulting from an abortion has been exceptionally low for decades. Between 1978 and 2007, the national mortality rate, as reported in five-year periods by the Centers for Disease Control and Prevention, ranged from 0.52 per 100,000 (or 0.00052 percent) to 0.78 per 100,000 (or 0.00078 percent).[6] Between 2008 and 2011, the most recent period for which data is available, the national

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[4] Under Texas law, the term "abortion facility" applies to providers of abortions, such as outpatient clinics, that are not hospitals, ASCs, or physicians' offices (unless the office performs more than fifty abortions in any twelve-month period). Tex. Health & Safety Code Ann. § 245.004; *Whether Abortion Facilities that are Exempt from Licensing Under Section 245.004 of the Health and Safety Code are Subject to Regulation by the Texas Department of Health Under Chapter 245*, Op. No. GA-0212, at 1 & n.4 (Tex. Att'y Gen. July 7, 2004). In this brief, amici use the terms "facilities" and "clinics" interchangeably.

[5] Amici are aware that, in 2003, Texas enacted a law providing that abortions at sixteen weeks of gestation and later be performed only in ASCs or hospitals. Tex. Health & Safety Code Ann. § 171.004. Amici confine their statements here to abortions occurring prior to sixteen weeks of gestation, which were performed legally in clinics and physicians' offices prior to the enactment of H.B. 2.

[6] Pazol et al., *Abortion Surveillance—United States, 2012*, 64 Morbidity & Mortality Wkly. Rep. 1, 11, 40 tbl. 23 (2015).

mortality rate was 0.73 per 100,000 (or 0.00073 percent).[7]

Publicly available data suggest that the abortion-related mortality rate in Texas prior to H.B. 2's full implementation was even lower than these national figures. According to Texas's own vital statistics, 993,844 abortions were performed between 2001 and 2013 (the years for which data is available online).[8] Only five deaths were reported in this thirteen-year period, accounting for a mortality rate of 0.5 per 100,000 (or 0.0005 percent).[9] From 2009 through 2013, there were no reported deaths in 360,059 abortions performed in Texas.[10]

The risk of major complications from the procedure is similarly low. In a comprehensive review of published studies, researchers found that most studies re-

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[7] *Id.*

[8] The calculations in the text accompanying this note and several subsequent notes are based on annual abortion statistics compiled by the Texas Department of State Health Services ("DSHS") in its *Vital Statistics Annual Reports*, http://www.dshs.state.tx.us/chs/vstat/annrpts.shtm (last updated Oct. 15, 2015).

[9] *Id.*

[10] *Id.* By contrast, in 2011 (the latest year graphed by DSHS), the average maternal mortality rate in Texas was 24.4 per 100,000 live births (or 0.0244 percent); for black women, that rate was 67.3 per 100,000 (or 0.0673 percent). DSHS, *2014 Healthy Texas Babies: Data Book* 14 fig. 21 (2014). Similarly, one nationwide study found that the mortality risk associated with childbirth is approximately fourteen times higher than the risk associated with abortion. Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216-217 & tbl. 1 (2012) (analyzing data from 1998 to 2005).

ported a less than 0.5 percent risk of hospitalization following a first-trimester aspiration abortion.[11] The higher rates of hospitalization reported in some studies were associated with procedures done using general anesthesia, which is infrequently used for first-trimester aspiration abortions in office-based clinics in the United States.[12] Indeed, one recent U.S.-based study found that the risk of major complications (uterine perforation, infection, and hemorrhage) from first-trimester aspiration abortions—the most common abortion procedure in Texas—is just 0.05 percent.[13]

Moreover, there is no medically sound reason to assume that abortions performed in a hospital or ASC setting are safer than those performed in a clinic or of-

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[11] White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434, 435 tbl. 7 (2015). The rate of major complications across all abortion procedures, including medication and second-trimester abortions, is similarly low. *See* Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 176 fig. 1, 181 (2015) (using 2009-2010 data from California and finding a 0.23 percent risk of abortion complications that might require hospital admission, surgery, or blood transfusion).

[12] White et al., *supra* note 11, at 434.

[13] Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Pub. Health 454, 458 & tbl. 2 (2013) (using 2007-2011 data from California); DSHS, *Vital Statistics Annual Reports*, *supra* note 8 (data by type of procedure); *see also* White et al., *supra* note 11, at 434 ("Major complications following first-trimester aspiration abortion were very rare").

fice.[14] The above-referenced comprehensive review of research found that "the percentage of abortions that resulted in major complications necessitating intervention was not higher in office-based clinics compared to ASCs and hospital-based clinics but rather was similar across settings."[15] Texas's mortality statistics point to the same conclusion. In the five years during which Texas had no reported abortion-related deaths, the overwhelming majority of abortions—83 percent—were performed in outpatient clinics or physicians' offices, not in ASCs or hospitals.[16] From 2001 to 2013, when Texas statistics reflected an exceedingly low mortality rate of 0.5 per 100,000 abortions (or 0.0005 percent), 91 percent of abortions were performed in outpatient clinics or physicians' offices.[17] Nationally, 95

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[14] Peacock et al., *Transition to Office-Based Obstetric and Gynecologic Procedures: Safety, Technical, and Financial Considerations*, 58 Clinical Obstetrics & Gynecology 418, 427 (2015) ("[F]irst-trimester aspiration abortions performed in an office are as safe as those performed in hospitals."); Paul, *Office Management of Early Induced Abortion*, 42 Clinical Obstetrics & Gynecology 290, 292 (1999) ("Compared with hospital-based procedures, abortions in ambulatory settings are comparably safe[.]"); *see also* Grimes et al., *Abortion Facilities and the Risk of Death*, 13 Fam. Plan. Persp. 30, 31 (1981) (mortality rates for first-trimester abortions are similar for hospitals and nonhospital facilities); Grimes et al., *Comparative Risk of Death from Legally Induced Abortion in Hospitals and Nonhospital Facilities*, 51 Obstetrics & Gynecology 323, 324 (1978) (same).

[15] White et al., *supra* note 11, at 435. White and her colleagues also concluded that "legislation requiring facilities where abortions are performed to meet ASC standards is unlikely to lead to measurable improvement in complications from first-trimester aspiration abortion." *Id.*

[16] DSHS, *Vital Statistics Annual Reports*, *supra* note 8.

[17] *Id.*

percent of abortions are performed in nonhospital settings.[18]

In sum, outpatient clinics and physicians' offices are safe places to obtain abortions.[19] Amici are aware of no medical basis for a mandate that abortion clinics meet the standards for ASCs.

B. H.B. 2's ASC Requirement Imposes Medically Unnecessary Demands On Abortion Facilities

Requiring that an abortion clinic meet the standards for ASCs has no medical purpose because of the nature and simplicity of abortion procedures. ASCs are meant to provide environments in which invasive surgeries historically performed in hospitals can be performed outside a hospital-based setting. Abortion procedures, however, do not require an incision into a woman's body and do not expose sterile tissue to the external environment. The performance of such procedures thus does not require a hospital-based or related outpatient setting. Nor is there any medical purpose or principled reason for Texas law to require abortion facilities, but not other facilities that perform similar or riskier outpatient procedures, to meet ASC standards.

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[18] Rock & Jones, *TE Linde's Operative Gynecology* 783 (10th ed. 2011); Peacock et al., *supra* note 14, at 427 (same); *see also* Joyce, *The Supply-Side Economics of Abortion*, 365 New Eng. J. Med. 1466, 1466-1467 (2011) (94 percent of all abortions take place in clinics).

[19] *See* ACOG, *Frequently Asked Questions, Induced Abortion* 1 (2015); *see also* Rock & Jones, *supra* note 18, at 783.

1. Abortion procedures do not require the full operating theater or external sterility precautions that are mandated by H.B. 2

The physical plant requirements mandated by H.B. 2—such as the presence of an operating room—are medically unnecessary for abortion procedures. As an initial matter, an increasingly large percentage of early abortions are medication abortions rather than surgical abortions.[20] No designated procedure space is required for medication abortions because the procedure involves administering prescription pills that induce pregnancy termination, which then typically occurs at home.[21]

Even surgical abortions, however, do not require an operating room. To conduct a first-trimester surgical abortion, the clinician has the patient recline on an examination table, taking the same position as for many gynecological exams. Few personnel are involved; little is required by way of equipment. The procedure is not commonly performed using general anesthesia, so designated space for related equipment storage is not generally required.[22] Surgical abortions simply do not require the size, layout, or equipment of a full operating

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[20] Pazol et al., *supra* note 6, at 8 (use of early medication abortion increased from 8.5 percent of abortions in 2003 to 20.4 percent in 2012).

[21] *See* ACOG, *Practice Bulletin Number 143, Medical Management of First-Trimester Abortion*, 123 Obstetrics & Gynecology 676, 677-678 (2014) (providing current evidence-based guidelines for medication abortion).

[22] In any event, as noted below, Texas law does not require that procedures using general anesthesia be performed in a facility that meets ASC standards. *See infra* note 30 and accompanying text.

theater. In this respect, they are no different than many procedures used for the management of miscarriages, which are also commonly addressed in office settings.[23]

Moreover, many of the burdensome construction requirements contained in the ASC regulations that are designed to maintain a sterile environment—such as restricted-access surgical suites, one-way traffic flow patterns, scrub equipment, and special ventilation units—are unnecessary in abortion clinics.[24] This is because clinicians performing abortions access the uterus through the vagina, which is known as a "clean-contaminated field" and is not naturally a sterile space. Therefore, "[r]outine sterile precautions (e.g., drapes, caps, masks, and gowns) are unnecessary"[25] under accepted medical practice for abortions. Indeed, accepted medical practice requires only that the clinician use sterile instruments and "ensure[] that the tips of instruments never contact non-sterile surfaces before entering the uterus."[26]

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[23] *See infra* note 29 and accompanying text.

[24] One specific example of a structural element designed to maintain a highly sterile environment in ASCs that is superfluous in the abortion context is the requirement that ASCs have operating rooms with ceilings that are "monolithic from wall to wall ... , smooth and without fissures, open joints, or crevices and with a washable and moisture impervious finish." 25 Tex. Admin. Code § 135.52(f)(5)(C). While such a requirement may be advisable for procedures where sterile body tissue is exposed, abortions are not such procedures and such stringent construction regulations are unnecessary.

[25] Rock & Jones, *supra* note 18, at 784.

[26] Lohr & Lyus, *Dilatation and Evacuation*, in *Abortion Care* 88, 95 (Rowlands ed., 2014); *see also* Paul, *supra* note 14, at 294.

Respondents' argument before the court of appeals—that the external sterility requirements for ASCs are beneficial to abortion procedures because "surgical abortion involves invasive entry into the uterus"[27]—ignores the fact that, unlike some other obstetric and gynecological procedures (such as cesarean deliveries and abdominal hysterectomies), surgical abortions do not involve exposure of the uterus to the external environment. For this reason (among others), ensuring the sterility of the portions of the surgical instruments that make contact with the uterus is sufficient to achieve the sterility needed for the procedure. There is simply no credible argument that the sterility precautions mandated by H.B. 2 have an accepted scientific or medical basis.

2. Office-based surgery is common and Texas law does not require that facilities performing procedures with higher mortality rates than abortion meet the standards for ASCs

Office-based surgery is common, and for many gynecological procedures it is the prevailing practice.[28]

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[27] *See* Pet. App. 31a; Resp. C.A. Br. 13.

[28] *See, e.g.*, ACOG, *Patient Education Pamphlets: Colposcopy* (2013); ACOG, *Patient Education Pamphlets: Hysteroscopy* (2011); ACOG, *Patient Education Pamphlets: Endometrial Hyperplasia* (2012); ACOG, *Patient Education Pamphlets: Loop Electrosurgical Excision Procedure* (2013); Allen et al., *Pain Relief for Obstetric and Gynecologic Ambulatory Procedures*, 40 Obstetrics & Gynecology Clinics N. Am. 625, 631-640 (2013) (colposcopy, cervical biopsy, cervical dilation and uterine aspiration, IUD insertion, endometrial biopsy, hysteroscopy); Nichols et al., *A Comparative Study of Hysteroscopic Sterilization Performed In-Office Versus a Hospital Operating Room*, 13 J. Minimally Inva-

For example, incomplete miscarriages are commonly treated in office settings via uterine aspiration, which is the same procedure as that used for the majority of induced abortion procedures affected by H.B. 2.[29]

Indeed, consistent with accepted medical practice, Texas permits physicians to perform surgical and other procedures in an office setting, including surgical procedures that require general anesthesia (which generally increases a procedure's risk), and/or that have complication and mortality rates similar to or higher than those associated with abortion, without requiring that

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sive Gynecology 447, 449 (2006) (demonstrating the "feasibility and suitability of performing hysteroscopic sterilization in-office"); Peacock et al., *supra* note 14, at 425-431 (hysteroscopy, IUD retrievals, sterilization, uterine evacuation (including dilation and aspiration), among other procedures); Urman et al., *Safety Considerations for Office-Based Obstetric and Gynecologic Procedures*, 6 Revs. Obstetrics & Gynecology e8, e14 (2013) ("There is no evidence to substantiate office-based gynecologic procedures being inherently unsafe. On the contrary, gynecologists can perform procedures in the office setting in a safe, effective, efficient, patient-centered fashion.").

[29] Allen et al., *supra* note 28, at 632 (uterine aspiration is used for induced abortion and treatment of miscarriages and can be performed in an office setting); Dennis et al., *Barriers to and Facilitators of Moving Miscarriage Management Out of the Operating Room*, 47 Persp. on Sexual & Reprod. Health 141, 141, 143-144 (2015) (technical aspects of miscarriage management and induced abortion are the same); Peacock et al., *supra* note 14, at 427 (vacuum curettage is used for abortion and miscarriage management and can be performed in office setting); Godfrey et al., *Early Pregnancy Loss Needn't Require a Trip to the Hospital*, 58 J. Fam. Prac. 585, 588 (2009) (vacuum aspiration appropriate for office setting); DSHS, *Vital Statistics Annual Reports*, *supra* note 8 (data by procedure type).

the offices meet ASC standards.[30] For example, no law requires colonoscopies or liposuction to be performed in an ASC or hospital setting, despite the fact that the mortality rate for both procedures is higher than for abortion. The mortality rate for colonoscopy, for example, is 0.007 percent, ten times higher than the national mortality rate for abortion.[31] The mortality rate for liposuction is even higher, at approximately 0.02 percent.[32]

There is no medical purpose or principled reason for Texas law to require abortion facilities—but not other medical facilities that perform similar or riskier outpatient procedures—to meet ASC standards.

II. H.B. 2's Privileges Requirement Does Not Serve The Health Of Women In Texas

As with the ASC requirement, the Texas legislature's claimed purpose for requiring abortion providers to maintain admitting privileges at a local hospital is "to raise the standard and quality of care for women seeking abortions and to protect the health and welfare of

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[30] *See* 22 Tex. Admin. Code §§ 192.1-192.6 (providing guidelines for office-based use of different levels of anesthesia, including general anesthesia).

[31] Am. Soc'y for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745, 747 (2011). For a discussion of the low mortality rate associated with abortion, *see supra* notes 6-10 and accompanying text.

[32] Grazer & de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436, 441 (2000).

women seeking abortions."[33] But H.B. 2's privileges requirement provides no medical benefit and is inconsistent with prevailing medical practice. Clinicians may be denied admitting privileges for reasons unrelated to the quality of care they provide, and developments in modern medical practices, which emphasize communication between physicians who specialize in inpatient or outpatient settings, achieve continuity of care without regard to whether a woman's abortion provider has admitting privileges. Stated in plain terms, the privileges requirement does nothing to improve the health and safety of women.

A. Clinicians Are Denied Medical Privileges For Reasons Unrelated To Their Competency

Obtaining privileges can be difficult, if not impossible, for many clinicians, irrespective of the clinician's technical competence. For example, some academic hospitals will only allow medical staff membership for clinicians who also qualify for and accept faculty appointments. Other hospitals require that clinicians admit a certain number of patients, or perform a certain number of deliveries or major obstetric or gynecological surgeries in order to affiliate with the hospital. Providers who specialize in performing abortions are frequently unable to meet such requirements because abortion is a very safe procedure only rarely resulting in hospitalization.[34]

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[33] Pet. App. 25a (citing S. Comm. on Health & Human Servs., Bill Analysis, Tex. H.B. 2, 83d Leg., 2d C.S. 1 (2013)); Opp. 3, 22.

[34] *See, e.g.*, White et al., *supra* note 11, at 435 ("[S]ince the percentage of women requiring hospitalization is very low, physicians will be admitting few (if any) patients, which may make it difficult for them to maintain hospital privileges.").

These factors can—and do—result in a denial of admitting privileges. In this very case, the Fifth Circuit credited evidence that clinicians at Petitioner's clinic in McAllen have been denied privileges for reasons unrelated to their competency.[35] But the real-life impact of the privileges requirement is far more wide-ranging than the effect on the McAllen clinic. After H.B. 2's privileges requirement went into effect, nearly one-third of abortion clinics were forced to stop providing abortions.[36] Requiring that clinicians obtain hospital privileges—when such privileges may be denied for reasons unrelated to the quality of care that they provide—does not promote the wellbeing of Texas women.

B. H.B. 2's Privileges Requirement Is Inconsistent With Accepted Medical Practice And Provides No Benefit To Patient Care Or Health Outcomes

The privileges requirement is also inconsistent with prevailing medical practices, which achieve continuity of care independent of whether the clinician who performs the abortion has admitting privileges at a lo-

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[35] Pet. App. 70a-71a ("With respect to the admitting privileges requirement, Whole Woman's Health presented considerable evidence that Plaintiff Dr. Lynn and three unidentified physicians working at the McAllen facility were unable to obtain admitting privileges at local hospitals for reasons other than their competence."). There was also evidence in the record that a clinician from Petitioner's El Paso clinic was denied privileges for reasons unrelated to clinical competence, but the Fifth Circuit found it unnecessary to consider this evidence in reaching its decision. *Id.* at 72a & n.44.

[36] Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 Contraception 73, 74 (2014).

cal hospital.[37] Rather than requiring admitting privileges, accepted medical practice requires the abortion provider's facility to have a plan to provide prompt emergency services and (if needed) to transfer a patient to a nearby emergency facility if complications occur.[38] This practice ensures that, in the rare instance where a woman experiences a complication during or immediately after an abortion and needs hospital-based care,[39] she can be treated appropriately by a trained emergency-room clinician or the hospital's on-call specialist.[40] The care provided by that emergency-room clinician or on-call specialist occurs without regard to whether the woman's abortion provider has admitting privileges.

In fact, the transfer of care from the abortion provider to an emergency-room clinician is consistent with the broader practice throughout modern medicine for

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[37] *See* Inst. of Med., *Crossing the Quality Chasm: A New Health System for the 21st Century* 8-9 (2001) (recommending that health care be available 24 hours a day and that "[c]linicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care").

[38] ACOG, *Guidelines for Women's Health Care: A Resource Manual* 720 (4th ed. 2014) ("Clinicians who perform abortions ... should have a plan to provide prompt emergency services if a complication occurs and should establish a mechanism for transferring patients who require emergency treatment."); Nat'l Abortion Fed'n, *2015 Clinical Policy Guidelines* 42 (2015) (similar protocols).

[39] *See supra* notes 11-13 and accompanying text for a discussion of the rarity of abortion-related complications.

[40] *See* White et al., *supra* note 11, at 435 ("In the rare event that a hospital transfer is needed, the clinician who is most qualified to treat a woman experiencing a major complication may not be the one who performed the abortion.").

inpatient and outpatient care to be provided by practitioners who specialize in each setting.[41] It is no longer the case that the same clinician necessarily provides both outpatient and hospital-based care; rather, hospitals increasingly rely on "hospitalists" who provide care only in a hospital setting.[42] Communication and collaboration between specialized health care providers achieves continuity of care.[43] Indeed, prior to the enactment of H.B. 2, Texas law reflected the prevailing medical practice by requiring that abortion facilities have protocols to ensure that patients could be transferred to a hospital in the rare event of an emergency requiring hospital treatment.[44]

H.B. 2's privileges requirement also does nothing to assist Texas women in the rare event that they experience complications after returning home. As with any emergency, it is likely that a woman would seek treatment at her nearest hospital at the time it occurs.[45] Given the juxtaposition of H.B. 2's requirement that an abortion provider maintain privileges at a hospital within thirty miles of her clinic with the fact that the average Texas county is 111 miles from an abortion

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[41] *See, e.g.*, ACOG, Comm. on Patient Safety & Quality Improvement, *Committee Opinion Number 459, The Obstetric-Gynecologic Hospitalist*, 116 Obstetrics & Gynecology 237 (2010).

[42] *Id.* at 237.

[43] *See* Inst. of Med., *supra* note 37, at 9, 62, 133-134.

[44] 38 Tex. Reg. 6536, 6546 (Sept. 27, 2013) (requiring a "readily accessible written protocol for managing medical emergencies and the transfer of patients requiring further emergency care to a hospital," including a "working arrangement" with a physician who has admitting privileges at a local hospital).

[45] Upadhyay et al., *supra* note 11, at 176.

clinic,[46] it is unlikely that the hospital at which a woman seeks emergency medical care will be the hospital at which her provider maintains privileges. Nor would it be appropriate to transport a woman an additional distance to a hospital simply because that is the facility at which her abortion provider maintains privileges.[47]

There is thus no medical basis from which to conclude that women's health would be advanced by requiring that clinicians obtain the local privileges mandated by H.B. 2. Indeed, such a requirement is out of step with prevailing medical practice and imposes an unnecessary restriction on the ability of clinicians to provide abortion care.

Several federal courts have noted the lack of scientific basis for similar privileges requirements. In November, the U.S. Court of Appeals for the Seventh Circuit permanently enjoined enforcement of a substantially identical privileges requirement in a Wisconsin statute.[48] As relevant here, the court explained that "complications from an abortion are both rare and rarely dangerous" and "[a] woman who experiences complications from an abortion (either while still at the clinic where the abortion was performed or at home after-

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[46] Soffen, *How Texas Could Set National Template for Limiting Abortion Access*, N.Y. Times, Aug. 19, 2015, http://nyti.ms/1E36Zjc.

[47] Indeed, H.B. 2 elsewhere acknowledges that the prevailing practice is for a patient to receive emergency care at a facility near her home. Tex. Health & Safety Code Ann. § 171.0031(a)(2)(B) (requiring that a woman be given "the name and telephone number of the nearest hospital to the home of the pregnant woman at which an emergency arising from the abortion would be treated").

[48] *See Planned Parenthood of Wis., Inc.* v. *Schimel*, 806 F.3d 908 (7th Cir. 2015).

ward) will go to the nearest hospital, which will treat her regardless of whether her abortion doctor has admitting privileges."[49] It thus "makes no sense," the court concluded, "to abridge the constitutional right to an abortion on the basis of spurious contentions regarding women's health."[50]

In setting aside Alabama's privileges requirement, the U.S. District Court for the Middle District of Alabama found that mandating that abortion providers have local admitting privileges "falls outside the range of standard medical practice for complication care" for abortion procedures and "would, in reality, undermine the State's goal of continuity of care" because women in

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[49] *Id.* at 912.

[50] *Id.* at 920. Judge Manion dissented, citing in part a 2004 statement joined by amici AMA and ACOG, for the proposition that "admitting privileges" are a "core principle" of patient safety. *Id.* at 928 (Manion, J., dissenting). As the plain language of the 2004 statement makes clear, however, it is a core principle for physicians to have admitting privileges *or* a transfer agreement (with another physician or hospital) in place. *See id.* (discussion quoting Am. Coll. Surgeons, *Statement on Patient Safety Principles for Office-Based Surgery Utilizing Moderate Sedation/Analgesia, Deep Sedation/Analgesia, or General Anesthesia*, 89 Bull. Am. Coll. Surgeons 32, 33 (2004)). In Wisconsin, as in Texas, laws that predate the admitting privileges requirements mandate such agreements. *Id.* at 909 (majority opinion); *supra* note 44. Moreover, ACOG's recent publications, which reflect advances in accepted medical practices, make clear that ACOG does not recommend an admitting privileges requirement for abortion procedures. *See supra* note 2; ACOG, *Report of the Presidential Task Force on Patient Safety in the Office Setting* (2010) (compiling recommendations for office-based surgery, none of which require admitting privileges at a nearby hospital).

Alabama would lose local access to the clinics forced to close under the privileges requirement.[51]

As these courts have recognized, citing the relevant standards of care, a privileges requirement is unnecessary and provides no benefit to women's health.

III. H.B. 2 Jeopardizes Women's Health By Restricting Access To Safe And Legal Abortion

Not only are H.B. 2's ASC and privileges requirements entirely unnecessary, there is incontrovertible evidence that they are impeding women's access to quality abortion care. That these restrictions are making abortion more difficult and expensive to obtain, imposing new burdens on women who can least afford them, is amply documented by Petitioners and other amici.[52] Amici here write separately to address the several ways in which these burdens are known to jeopardize women's health.

At the outset, it is beyond question that delays in obtaining an abortion can compromise a woman's health; abortion should be performed safely and as early as possible.[53] That is true notwithstanding that abortion procedures are among the safest medical pro-

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[51] *Planned Parenthood Se., Inc.* v. *Strange*, 33 F. Supp. 3d 1330, 1372 (M.D. Ala.), *supplemented by* 33 F. Supp. 3d 1381 (M.D. Ala.), *and amended by* 2014 WL 5426891 (M.D. Ala. Oct. 24, 2014).

[52] *See* Pet. Br. 23-26, 49-50; *see also, e.g.*, Soffen, *supra* note 46 (noting that the average Texas county is 111 miles from a facility that provides abortions; if the Fifth Circuit's judgment is allowed to stand, the typical cost of an abortion in Texas would rise 15 percent, to $701).

[53] *See* ACOG, *College Statement of Policy, Abortion Policy*, *supra* note 2, at 2.

cedures. Complications, as rare as they are, increase with the length of the pregnancy.[54] The mortality rate for abortions occurring prior to thirteen weeks of gestation, the period during which most abortions are performed,[55] is no more than 0.4 per 100,000.[56] The mortality rate increases significantly, however, throughout the second trimester to 1.7 per 100,000 when the abortion is performed between thirteen and fifteen weeks, 3.4 per 100,000 when the abortion is performed between sixteen and twenty weeks, and 8.9 per 100,000 when the abortion is performed at twenty-one weeks or later.[57]

Research confirms that, following the enactment of H.B. 2, women have been prevented from obtaining timely and legal abortions. During the first six months following the implementation of H.B. 2's privileges requirement, when nearly one-third of Texas's clinics closed, there was a noticeable increase in the proportion of abortions performed in the second trimester, as compared with the prior twelve-month period,[58] exposing those women to risks above what they would have

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[54] *See* Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 735 (2004).

[55] Pazol et al., *supra* note 6, at 1 (noting that "nearly all" abortions are performed at or prior to thirteen weeks of gestation).

[56] Bartlett et al., *supra* note 54, at 733 tbl. 2.

[57] *Id.*; *see also* Grossman et al., *Complications After Second Trimester Surgical and Medical Abortion*, 16 Reprod. Health Matters 173, 173 (2008) (citing the Bartlett data).

[58] Grossman et al., *Change in Abortion Services After Implementation of a Restrictive Law in Texas*, 90 Contraception 496, 498-499 & tbl. 1 (2014).

experienced had they obtained abortions earlier in their pregnancies.[59] During that same period, the number of abortions reported in Texas declined by 13 percent, which researchers observed was a steeper drop "than that reported for both Texas and the nation in recent years."[60] The number of abortions reported in the Lower Rio Grande Valley—the home of a particularly vulnerable population of women—declined even further.[61]

Amici are concerned that these declines may indicate not a true reduction in the incidence of abortion, but rather, among other possibilities (such as obtaining care in another state), a rise in illegal abortions, including self-induced abortions. Data suggest that there is a relationship between restricted access and the use of unsafe means to end an unwanted pregnancy, and self-induction puts women at risk for injury or death caused by, among other things, fake or expired medications, improper dosage, lack of instructions, trauma, or the absence of medical supervision.[62]

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[59] *See* Grossman et al., *Public Health Threat*, *supra* note 36, at 74.

[60] Grossman et al., *Change in Abortion Services*, *supra* note 58, at 499 tbl. 1, 500.

[61] *See id.* at 499. For women in the Valley, the decline may deepen even more because approximately half of women from the Valley who obtained abortions during this time period did so at a clinic in Corpus Christi, which has since closed. *See id.*

[62] *See* ACOG, *Committee Opinion Number 613*, *supra* note 2, at 1061 ("[H]istorical and contemporary data show that where abortion is illegal or highly restricted, women resort to unsafe means to end an unwanted pregnancy, including self-inflicted abdominal and bodily trauma, ingestion of dangerous chemicals, self-medication with a variety of drugs, and reliance on unqualified

A statewide survey of Texas women in January 2015 found that self-induction was more likely to occur among Latinas who live in a county bordering Mexico and women who reported difficulty obtaining reproductive health services due to barriers such as the cost of services or difficulty arranging transportation.[63] "Given that [both] populations ... are among those that have been most directly affected by the closure of abortion clinics in the state [due to H.B. 2]," the researchers found cause to "suspect that abortion self-induction will increase as clinic-based care becomes more difficult to access."[64] The record evidence in this case points in the same direction. The court of appeals credited abortion providers' testimony "regarding the difficulties that women in the Rio Grande Valley faced after the McAllen facility ceased performing abortions, including that the clinic saw an increase in self-attempted abortion."[65]

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abortion providers."); Shah et al., *Access to Safe Abortion: Progress and Challenges Since the 1994 International Conference on Population and Development (ICPD)*, 90 Contraception S39, S40 (2014) (noting that "legal restrictions result in women self-inducing abortion or seeking it clandestinely"); Grossman et al., *Public Health Threat*, *supra* note 36, at 74 ("Evidence from other countries indicates that severely restricting abortion does not reduce its incidence—it simply makes unsafe abortion more common.").

[63] Grossman et al., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas*, Texas Policy Evaluation Project Research Brief 2, 4 (2015).

[64] *Id.* at 4.

[65] Pet. App. 65a; *see also* Hellerstein, *The Rise of the DIY Abortion in Texas*, The Atlantic, June 27, 2014, http://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/ (reporting on self-induction in the Rio Grande Valley).

In sum, far from safeguarding women's health, requirements imposed by H.B. 2 jeopardize women's health by impeding, if not outright preventing, access to safe, legal, evidence-based abortion care. Amici oppose laws that, in the absence of any valid medical justification, have this potentially devastating result.[66]

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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[66] *See* ACOG, *College Statement of Policy, Abortion Policy*, *supra* note 2, at 2.